Learn These Tips to Diagnose Vulvodynia

BY DAMIAN MCDONAGH
EXPERT ANALYSIS FROM A SEMINAR ON WOMEN’S AND PEDIATRIC DERMATOLOGY

SAN FRANCISCO – Although identification of the cause of a woman’s vulvar pain can be a challenge, once vulvodynia is diagnosed there are many management strategies that can provide relief, according to Dr. Libby Edwards.

Women who present with vulvar pain may describe burning, stinging, acheing, irritation, soreness, tingling, or tension sensations. These painful symptoms generally point to herpes simplex virus infection or vulvodynia, Dr. Edwards said at the seminar sponsored by Skin Disease Education Foundation.

Making the Diagnosis

One diagnostic tip is to distinguish vulvar pain from vulvar itch because the etiologies are usually different. Rule out a yeast infection when patients report acute itching, for example. In contrast, if the itch is more chronic, the woman may have lichen simplex chronicus or, less commonly, lichen sclerosus, she noted.

Skin disease, infection, and specific types of neuropathic pain (such as pudendal neuralgia and post-herpetic neuropathy) are other considerations in the differential diagnosis, said Dr. Edwards, chief of dermatology at Carolinas Medical Center, Charlotte, N.C.

Consider skin diseases like lichen planus and desquamative inflammatory vaginitis. Also, if a skin eruption from postherpetic neuralgia is suspected, remember it occurs only with herpes zoster and not simplex virus infections.

Vulvodynia is a symptom, often multifactorial, and not a disease, Dr. Edwards said. Not surprisingly, psychological dysfunction is a prominent feature for some women.

Diagnose the extent of a woman’s vulvodynia because surgical excision is indicated for only a subset of patients – those with vestibulodynia or vulvar vestibulitis syndrome. Pain arises only when provoked, versus other localized conditions such as lichen sclerosus or hemivulvodynia where pain can occur spontaneously as well.

By exclusion, generalized pain is not localized and can be migratory. For more information on localized versus generalized vulvodynia, Dr. Edwards recommended the European Association of Urology guidelines for diagnosis, therapy, and follow-up of patients with chronic pelvic pain (Eur. Urol. 2004;46:681-9).

Treatment Recommendations

Both general and specific strategies are important for the management of vulvodynia, Dr. Edwards said. For example, instruct the patient to avoid irritants, overwashing the area, and excessive use of topical medications. Educate patients using written materials or handouts and refer them to the National Vulvodynia Association Web site (www.nva.org) for more information.

Xylocaine (lidocaine) jelly 2% or Xylocaine ointment 5%, as needed, can provide relief, Dr. Edwards said. The 5% ointment can be applied to the vestibule overnight with occlusion (using a cotton ball) to break the pain cycle.

Other topical agents to consider include estrogen, nitroglycerin, and amitriptyline 2%/bactol 2% in an aqueous solution.

On the other hand, avoid topical testosterone preparations, corticosteroids, and antichandal medications (unless a yeast infection is confirmed), Dr. Edwards advised.

Specific oral medications with efficacy for vulvodynia relief include gabapentin and other anticonvulsants, venlafaxine, and pregabalin.

Women with vulvodynia might also benefit from injections of alpha-interferon, corticosteroids, or botulinum toxin, said Dr. Edwards. Nerve blocks may also provide relief.

Although there are many management strategies, a combination of physical therapy and oral medication to treat neuropathy is the most important intervention, Dr. Edwards said. The patient should be referred to a physical therapist with expertise in pelvic floor therapy.

Approximately 80% of patients improve substantially, although a complete response can take 7-8 months, she said. Regular exercise can optimize outcomes for most women.

Although the description of vulvodynia has changed many times since the late 1970s, the current consensus is that it involves pelvic floor dysfunction that triggers neuropathic pain.

Poor pelvic floor muscle strength, high resting tension, and irritability of muscles can each contribute to the associated discomfort. In addition, many women have urinary tract symptoms or comorbid conditions such as irritable bowel syndrome.

Most of the medications mentioned in this article are “off label” for vulvodynia. Dr. Edwards said she had no relevant disclosures.

SDEF and this news organization are owned by Elsevier.